

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

**In the Matter of the Accusation)
Against:)**

ERIC JEROME GRIGSBY, M.D.)

Case No. 12-2013-235257

**Physician's and Surgeon's)
Certificate No. G64848)**

Respondent)

DECISION

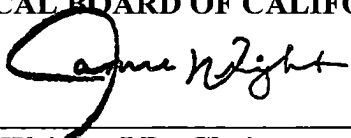
The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 16, 2017.

IT IS SO ORDERED July 17, 2017.

MEDICAL BOARD OF CALIFORNIA

By:



**Jamie Wright, J.D., Chair
Panel A**

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 MACHAELA M. MINGARDI
Deputy Attorney General
4 State Bar No. 194400
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 703-5696
6 Facsimile: (415) 703-5480
Attorneys for Complainant

7
8 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. 12-2013-235257

11 **ERIC GRIGSBY, M.D.**

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER FOR PUBLIC
REPRIMAND**

12 P.O. Box 5510
13 Napa, CA 94581

14 Physician and Surgeon's Certificate No.
15 G64848

16 Respondent.

17 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
18 entitled proceedings that the following matters are true:

19 **PARTIES**

20 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
21 of California (Board). She brought this action solely in her official capacity and is represented in
22 this matter by Xavier Becerra, Attorney General of the State of California, by Machaela M.
23 Mingardi, Deputy Attorney General.

24 2. Respondent Eric Grigsby, M.D. (Respondent) is represented in this proceeding by
25 attorney Peter Osinoff, Esq., whose address is: 355 South Grand Avenue, Suite 1750, Los
26 Angeles, CA 90071-1562.

27 3. On or about December 27, 1988, the Board issued Physician and Surgeon's
28 Certificate No. G64848 to Eric Grigsby, M.D. (Respondent). The Physician and Surgeon's

1 Certificate was in full force and effect at all times relevant to the charges brought in Accusation
2 No. 12-2013-235257, and will expire on October 31, 2016, unless renewed.

3 JURISDICTION

4 4. Accusation No. 12-2013-235257 was filed before the Board, and is currently pending
5 against Respondent. The Accusation and all other statutorily required documents were properly
6 served on Respondent on May 27, 2015. Respondent timely filed his Notice of Defense
7 contesting the Accusation.

8 5. A copy of Accusation No. 12-2013-235257 is attached as Exhibit A and incorporated
9 herein by reference.

10 ADVISEMENT AND WAIVERS

11 6. Respondent has carefully read, fully discussed with counsel, and understands the
12 charges and allegations in Accusation No. 12-2013-235257. Respondent has also carefully read,
13 fully discussed with counsel, and understands the effects of this Stipulated Settlement and
14 Disciplinary Order.

15 7. Respondent is fully aware of his legal rights in this matter, including the right to a
16 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine
17 the witnesses against him; the right to present evidence and to testify on his own behalf; the right
18 to the issuance of subpoenas to compel the attendance of witnesses and the production of
19 documents; the right to reconsideration and court review of an adverse decision; and all other
20 rights accorded by the California Administrative Procedure Act and other applicable laws.

21 8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
22 every right set forth above.

23 CULPABILITY

24 9. Respondent understands and agrees that the charges and allegations in Accusation
25 No. 12-2013-235257, if proven at a hearing, constitute cause for imposing discipline upon his
26 Physician and Surgeon's Certificate.

27 10. For the purpose of resolving the Accusation without the expense and uncertainty of
28 further proceedings, Respondent agrees that his Physician and Surgeon's Certificate is subject to

1 discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the
2 Disciplinary Order below.

3 RESERVATION

4 11. The admissions made by Respondent herein are only for the purposes of this
5 proceeding, or any other proceedings in which the Medical Board of California or other
6 professional licensing agency is involved, and shall not be admissible in any other criminal or
7 civil proceeding.

8 CONTINGENCY

9 12. This Stipulation shall be subject to approval by the Medical Board of California.
10 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
11 Board of California may communicate directly with the Board regarding this Stipulation and
12 settlement, without notice to or participation by Respondent or his counsel. By signing the
13 Stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
14 to rescind the Stipulation prior to the time the Board considers and acts upon it. If the Board fails
15 to adopt this Stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
16 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
17 action between the parties, and the Board shall not be disqualified from further action by having
18 considered this matter.

19 13. The parties understand and agree that Portable Document Format (PDF) and facsimile
20 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
21 signatures thereto, shall have the same force and effect as the originals.

22 14. In consideration of the foregoing admissions and stipulations, the parties agree that
23 the Board may, without further notice or formal proceeding, issue and enter the following
24 Disciplinary Order:

25
26
27 //

28 //

1 DISCIPLINARY ORDER

2 A. PUBLIC REPRIMAND

3 IT IS HEREBY ORDERED that Respondent Eric Grigsby, M.D., as holder of Physician
4 and Surgeon's Certificate No. G64848, shall be and hereby is publicly reprimanded pursuant to
5 Business and Professions Code section 2227. This Public Reprimand is issued as a result of the
6 following:

7 From August 2010 to June 2013, Respondent failed to adequately monitor and respond to
8 urine drug screen results for Patient P.D., and/or failed to adequately document treatment
9 decisions for Patient P.D.

10 ACCEPTANCE

11 I have carefully read the above Stipulated Settlement and Disciplinary Order for Public
12 Reprimand and have fully discussed it with my attorney, Peter Osinoff, Esq. I understand the
13 Stipulation and the effect it will have on my Physician and Surgeon's Certificate. I enter into this
14 Stipulated Settlement and Disciplinary Order for Public Reprimand voluntarily, knowingly, and
15 intelligently, and agree to be bound by the Decision and Order of the Medical Board of
16 California.


17
18 DATED: May 4, 2017



ERIC GRIGSBY, M.D.
Respondent

20
21 I have read and fully discussed with Respondent Eric Grigsby, M.D. the terms and
22 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
23 I approve its form and content.

24
25 DATED: May 9, 2017



PETER OSINOFF, Esq.
Attorney for Respondent

27 ENDORSEMENT

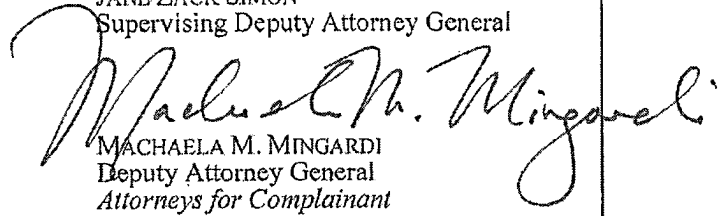
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
submitted for consideration by the Medical Board of California.

Dated: 5/10/2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General


MACHAELA M. MINGARDI
Deputy Attorney General
Attorneys for Complainant

SF2014410628
41746512.docx

Exhibit A

Accusation No. 12-2013-235257

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
MACHAELA M. MINGARDI
Deputy Attorney General
State Bar No. 194400
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5696
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Case No. 12-2013-235257

ERIC GRIGSBY, M.D.

**P.O. Box 5510
Napa, CA 94581**

**Physician's and Surgeon's Certificate No.
G64848**

Respondent.

ACCUSATION

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.
2. On or about December 27, 1988, the Medical Board of California issued Physician's and Surgeon's Certificate Number G64848 to Eric Grigsby, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2016, unless renewed.

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(b) Gross negligence.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

1 "(f) Any action or conduct that would have warranted the denial of a certificate.

2 "(g) The practice of medicine from this state into another state or country without meeting
3 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
4 apply to this subdivision. This subdivision shall become operative upon the implementation of the
5 proposed registration program described in Section 2052.5.

6 "(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
7 participate in an interview by the board. This subdivision shall only apply to a certificate holder
8 who is the subject of an investigation by the board."

9 6. Section 2242(a) provides that prescribing, dispensing or furnishing dangerous drugs
10 without an appropriate examination and a medical indication constitutes unprofessional conduct.

11 7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
12 adequate and accurate records relating to the provision of services to their patients constitutes
13 unprofessional conduct."

14 8. Section 725 of the Code states:

15 "(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering
16 of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated
17 acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of
18 the community of licensees is unprofessional conduct for a physician and surgeon"

19

20 **FIRST CAUSE FOR DISCIPLINE**

21 (Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts and/or
22 Incompetence and/or Excessive Prescribing related to the care of Patient P.D.)

23

24 9. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b),
25 and/or 2234(c), and/or 2234(d) of the Code in that Respondent committed unprofessional conduct
26 amounting to gross negligence and/or repeated negligent acts and/or incompetence in the care and
27 treatment of Patient P.D. Respondent is also subject to disciplinary action under sections 725 and
28 2242(a) of the Code in that Respondent excessively prescribed to Patient P.D. without a proper
medical indication. The circumstances are as follows:

1 10. On or about March 27, 2001, Patient P.D. suffered a Worker's Compensation injury
2 after heavy lifting while working at a hotel. She was 36 years old.

3 11. Patient P.D. first went to Respondent for treatment on October 4, 2001. She reported
4 that she was a former bartender with a history of alcohol abuse, but claimed to be clean for years.
5 Respondent's treatment plan for Patient P.D. included prescriptions for Oxycodone¹ and
6 Oxycontin,² which he prescribed to her for many years.

7 12. For example, in 2006, Respondent regularly prescribed Patient P.D. 60 milligrams
8 (mg) of Oxycontin twice a day and 5 mg of Oxycodone 8 times a day.

9 13. On March 13, 2006, Patient P.D. had an orthopedic Agreed Medical Evaluation with
10 another physician, Dr. M.S. He found that there was no structure abnormality in Patient P.D.'s
11 cervical spine. He stated that surgery was not indicated and recommended a regular exercise
12 program. He believed that Patient P.D. was chemically dependent and suggested a major change
13 in the direction of her medical care because of the great gulf between the objective findings and
14 the huge amount of opioids she was taking.

15 14. Respondent continued to maintain Patient P.D. on high doses of opioids. Respondent
16 also treated Patient P.D. with occipital nerve stimulation for her headaches, but she reported little
17 improvement of her condition over time.

18 15. On or about April 4, 2006, Patient P.D.'s sister sent a letter to Respondent via
19 certified mail. The letter is in Patient P.D.'s chart and states that Patient P.D.'s family is greatly
20 concerned for her. More specifically, the letter states the following: Patient P.D.'s family
21 believes that she is abusing her pills and has been for quite some time. She has lied to
22 Respondent's office to get more pills. Patient P.D. has forgotten her children. She has forgotten
23 where she left them. She has forgotten to pick them up from school. She has been found asleep
24

25 ¹ Oxycodone is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic
26 effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a dangerous drug as
27 defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055(b)(1) of the
28 Health and Safety Code.

² Oxycontin is a trade name for oxycodone hydrochloride controlled-release tablets. It is a dangerous drug as
defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055(b)(1) of the
Health and Safety Code.

1 and unable to wake up. She has gotten violent when drinking alcohol with her medication. Other
2 friends have asked the family what is going on with her. They are concerned that Patient P.D.'s
3 children will be taken away from her. They are concerned about her driving and being "under the
4 influence." The letter begs for help and a response from Respondent.

5 16. Respondent, in his interview with the Board, stated that he had never seen this letter.
6 He also stated that he had never seen any written correspondence from Patient P.D.'s family
7 members. However, in a letter dated June 28, 2006 to the State Compensation Insurance Fund,
8 Respondent wrote the following: "I have recently received a letter from the patient's family who
9 has concerns about the patient's mental status and possible over use of medications" He also
10 states that Patient P.D. admitted to him that she used alcohol "on an occasional basis." The letter
11 is signed by Respondent.

12 17. Respondent continued to maintain Patient P.D. on high doses of opioids. For
13 example, on January 11, 2010, she was taking 40 mg of Oxycontin 4 times a day and 15 mg of
14 Oxycodone 6 times a day.

15 18. On or about August 21, 2012, Patient P.D. reported to Respondent that she could only
16 sit, stand or walk for 0-1 minutes. If true, this would be a significant finding and would warrant a
17 change in her treatment plan, including appropriate referrals to specialists. Respondent
18 documented no particularized response to Patient P.D.'s report, which appears inconsistent with
19 other data, such as the fact that she drove herself to Respondent's office and walked with no
20 assisted devices.

21 19. On December 13, 2012, Patient P.D. was hospitalized at Queen of the Valley Hospital
22 for an acutely altered mental state. Her UDS (Urine Drug Screen) were positive for oxycodone
23 and negative for alcohol. She was discharged on December 20, 2012. A letter dated January 3,
24 2013 written by Respondent indicates that Patient P.D.'s opioids were greatly reduced in the
25 hospital due to Patient P.D.'s altered mental status, which then "quickly cleared."

26 20. Despite this, after Patient P.D. was released from the hospital, Respondent increased
27 her Oxycontin from 10 mg twice a day to 20 mg twice a day, and started Oxycodone again at 5
28

1 mg six times a day. By February 19, 2013, she was prescribed 30 mg of Oxycodone up to 5 times
2 a day. The reason for either increase is absent from Patient P.D.'s medical records.

3 21. In May 2013, Patient P.D. was seen again at Queen of the Valley hospital, this time
4 for a fall.

5 22. During Respondent's treatment of Patient P.D., alcohol was found in Patient P.D.'s
6 UDS many times, including samples taken on the following dates since August 1, 2010: August
7 11, 2010; February 16, 2011; April 9, 2012; July 18, 2012; September 18, 2012; and July 25,
8 2013. Patient P.D. claimed the positive results were from hand sanitizer, but each of these results
9 is consistent with the use of alcohol and inconsistent with the use of hand sanitizer.

10 23. At some point in 2013, Patient P.D. became homeless and began living out of her car.
11 Respondent admitted during his interview with the Board that he was aware that Patient P.D. had
12 become homeless.

13 24. On December 9, 2013, Patient P.D.'s sister called Respondent's office and stated that
14 Patient P.D. was homeless, living in her car, selling her pain medications and drinking "gallons"
15 of vodka per day.

16
17 **SECOND CAUSE FOR DISCIPLINE**

18 (Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts and/or
19 Incompetence and/or Excessive Prescribing related to the care of Patient N.P.)

20 25. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b),
21 and/or 2234(c), and/or 2234(d), and/or 2266 of the Code in that Respondent committed
22 unprofessional conduct amounting to gross negligence and/or repeated negligent acts and/or
23 incompetence in the care and treatment of Patient N.P., and/or failed to maintain adequate and
24 accurate records for Patient N.P. Respondent is also subject to disciplinary action under sections
25 725 and 2242(a) of the Code in that Respondent excessively prescribed to Patient N.P. without a
26 proper medical indication. The circumstances are as follows:

27 26. Patient N.P., a patient on Medicare, was first referred to Respondent more than ten
28 years ago in October of 2004. She had multiple medical problems, including but not limited to

1 the following: Diabetes mellitus with secondary gastric paresis with abdominal pain; chest wall
2 pain, interstitial cystitis and pelvic pain; fibromyalgia; and intestinal pseudo-obstruction with
3 malabsorption. Patient N.P. was functionally disabled. Multiple specialists have been involved
4 in her care.

5 27. Patient N.P. has been maintained on opioids, often at very high levels. For example,
6 in March of 2012, Respondent prescribed Patient N.P. Actiq³ at 1600 mcg 8 times a day, a
7 fentanyl⁴ patch at 200 mcg per day, and a hydrocodone/APAP⁵ elixir at 60 ml per day. She also
8 was prescribed Carisoprodol⁶, which goes by the trade name Soma, and Temazepam⁷ by her
9 primary care physician (PCP).

10 28. On January 9, 2013, Patient N.P. reported to Respondent that she had altered speech
11 and an altered mental status on Christmas Eve of 2012, and that it took three days for her to return
12 to her normal state.

13 29. On August 7, 2013, Patient N.P. reported to Respondent that her family called her an
14 "addict" and said that she was experiencing periods of amnesia. In response, Respondent
15 requested that her PCP decrease her dosage of Soma from 6 tablets per day to 3 tablets per day.
16 This reduced dosage of Soma, however, is still a sedating dose.

17
18 ³ Actiq, a trade name for oral transmucosal fentanyl citrate, is a potent opioid analgesic, intended for oral
19 transmucosal administration. It is a Schedule II controlled substance as defined by section 11055 of the Health and
20 Safety code. Actiq is indicated only for the management of breakthrough cancer pain in patients with malignancies
21 who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain.

22 ⁴ Fentanyl is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code.
23 Fentanyl is a strong opioid medication and is indicated only for treatment of chronic pain that cannot be managed by
24 lesser means. Fentanyl presents a risk of serious or life-threatening hypoventilation. Fentanyl can produce drug
25 dependence similar to that produced by morphine and has the potential for abuse. It is physically and psychologically
26 addictive.

27 ⁵ Hydrocodone/APAP, hydrocodone with acetaminophen, is a Schedule III controlled substance and narcotic
28 as defined by section 11056(e) of the Health and Safety Code. Repeated administration of hydrocodone over a course
of several weeks may result in psychic and physical dependence. At high levels, acetaminophen can cause liver and
kidney toxicity.

⁶ Carisoprodol, commonly sold under the trade name Soma, is a muscle-relaxant and sedative. It is a
dangerous drug as defined in section 4022. Carisoprodol combined with other psychotropic drugs may be addictive
and appropriate caution should be exercised in administration to patients with compromised liver or kidney functions.

⁷ Temazepam is a hypnotic agent. It is a dangerous drug as defined by section 4022 and a Schedule IV
controlled substance and narcotic as defined by Section 11057(d) of the Health and Safety Code. Temazepam is
indicated for the short-term treatment of insomnia (generally 7 to 10 days). As with any hypnotic, caution must be
exercised in administering temazepam to individuals known to be addiction prone.

1 30. Two days later on August 9, 2013, Patient N.P. called Respondent's office and said
2 she "blacked out" and hit her head on a cabinet.

3 31. Following her August 7, 2013 visit, Patient N.P. was worked up by other specialists,
4 including her neurologist. Testing, such as an electroencephalogram (EEG), did not provide any
5 explanation for the periods of amnesia or for the "black out."

6 32. On September 5, 2013, Patient N.P. reported to Respondent that her mother threw out
7 some of her medications because she felt she was abusing them.

8 33. On October 30, 2013, Patient N.P.'s level of fentanyl was lowered. The note
9 regarding the decrease in the fentanyl dosage merely states "Black outs" - pt. agrees to taper COT
10 (sic) as she believes the Soma keeps her functioning." There is no rationale stated as to why the
11 fentanyl dosage was decreased.

12 34. In summary, Patient N.P. was on high doses of opioids, with a very high morphine
13 equivalent, along with sedating doses of Soma. Respondent made no effort to either lower her
14 opioid dosage to see if that affected her "blacking out" or to understand why her family felt she
15 was abusing her medications. If the fentanyl was lowered in response to these episodes, it came
16 more than two months after the fact and was never documented. In fact, Respondent's
17 documentation for this change was so poor that during his interview with the Board, he
18 incorrectly stated that the change in the fentanyl dosage was an increase to compensate for the
19 stopping of the Actiq, which had been done several months before, rather than a decrease.

20 35. The failure to investigate the roll of Patient N.P.'s opioid usage in her "blacking out"
21 or her family's impression that she was an "addict" abusing her pain medication is a departure
22 from the standard of care. The failure to keep accurate records as described above is an additional
23 departure from the standard of care.

24 **THIRD CAUSE FOR DISCIPLINE**

25 (Unprofessional Conduct: Incompetence and/or Failure to Maintain Adequate and Accurate
26 Records related to the care of Patient B.B.)

27 36. Respondent is subject to disciplinary action under sections 2234, and/or 2234(c),
28 and/or 2234(d) and/or 2266 of the Code in that Respondent was incompetent in the care and

1 treatment of Patient B.B. and/or failed to maintain adequate and accurate records for Patient B.B.

2 The circumstances are as follows:

3 37. Respondent saw 26-year-old Patient B.B., an Iraq war veteran, beginning in February
4 of 2012 regarding complaints of back, shoulder and knee pain. By January 14, 2013, Respondent
5 was prescribing Patient B.B. 8 pills of Hydrocodone/APAP per day. As noted above,
6 Hydrocodone/APAP, also known by the trade name Norco, is a Schedule III controlled substance
7 and narcotic as defined by section 11056(c) of the Health and Safety Code. Repeated
8 administration of hydrocodone over a course of several weeks may result in psychic and physical
9 dependence. The usual adult dosage is one or two tablets every four to six hours as needed for
10 pain. The maximum 24-hour dosage recommended is 6 tablets for chronic pain therapy, and a
11 maximum of 8 to 10 tablets for acute pain (less than two weeks). At high levels, acetaminophen
12 can cause liver and kidney toxicity.

13 38. During a 28-day period in 2013, Respondent prescribed Patient B.B. 480 pills of
14 Norco. Respondent prescribed Patient B.B. 120 tablets of Norco on 1/14/2013, 120 tablets of
15 Norco on 1/20/2013, 120 tablets of Norco on 2/4/2013, and 120 tablets of Norco on 2/11/2013.
16 This is a 60-day supply of opioids. The medical records for Patient B.B. do not explain why this
17 occurred. In fact, the medical records do not even demonstrate an awareness that an over-
18 prescription of opioids took place.

19 39. The standard of care requires that the rationale for why opioids are being prescribed
20 be documented. If there are early refills, the rationale for those refills should be provided. In this
21 case, there is no record in Patient B.B.'s medical chart that the 2/4/2013 or 2/11/2013
22 prescriptions were ever written. There is no explanation as to why the additional prescriptions
23 were necessary. The failure to document why Respondent over-prescribed opioids during this
24 time period is a departure from the standard of care.

25 40. In addition, three Urine Drug Screens taken from May 2012 to September 2012 for
26 Patient B.B. tested positive for alcohol. Despite these three screens showing alcohol use, there is
27 no discussion regarding this alcohol use in Patient B.B.'s chart. As noted above, Patient B.B. was
28 on daily opiates. Also as noted above, in his interview with the Board, the Respondent noted that

1 the use of alcohol with opiates is "unsafe." The failure to respond to this patient's use of alcohol,
2 and/or to document that response, under these circumstances is a departure from the standard of
3 care.

4 **PRAYER**

5 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
6 and that following the hearing, the Medical Board of California issue a decision:

- 7 1. Revoking or suspending Physician and Surgeon's Certificate Number G64848, issued
8 to Eric Grigsby, M.D.;
- 9 2. Revoking, suspending or denying approval of Eric Grigsby, M.D.'s authority to
10 supervise physician assistants, pursuant to section 3527 of the Code;
- 11 3. Ordering Eric Grigsby, M.D., if placed on probation, to pay the costs of probation
12 monitoring;
- 13 4. Taking such other and further action as deemed necessary and proper.
- 14

15
16 DATED: May 27, 2015


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

17
18
19
20
21 SF2014410628
41246580.doc
22
23
24
25
26
27
28